BEFORE THE ARIZONA MEDICAL BOARD

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In the Matter of

ROBERT D. CASTILLO, M.D.

Holder of License No. 11036 For the Practice of Medicine In the State of Arizona. Case No. MD-06-0621A

CONSENT AGREEMENT FOR DECREE OF CENSURE

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Robert D. Castillo, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

- 1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.
- 2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.
- This Consent Agreement is not effective until approved by the Board signed by its Executive Director.
- 4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

- 5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.
- 6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.
- 7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.
- 8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.
- 9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Fractitioner Data Bank and to the Arizona Medical Board's website.

- 10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.
- 11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

Robert D. CASTILLO, M.D.

Dated: 14mes 6,2009

FINDINGS OF FACT

- The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- Respondent is the holder of license number 11036 for the practice of allopathic medicine in the State of Arizona.
- The Board initiated case number MD-06-0621A after receiving complaints regarding Respondent's care and treatment of a forty-five year-old female patient ("TR").
- with TR for depression. Respondent did not document TR's psychiatric history, family history, her substance abuse history, her symptoms and his assessment of facts and findings including a mental status examination. Respondent diagnosed TR with Attention Deficient Hyperactivity Disorder, major depression, impulse control disorder, generalized anxiety disorder, mood disorder, Axis I, III and IV behavior and migraine headaches. There is no indication in TR's medical record for Respondent's diagnoses. Respondent prescribed TR Stattera, Adderall, Wellbutrin, Lithium, and Tegretol. Respondent also prescribed Lamictal. Lamictal is indicated for Bipolar Disorder, however, Respondent did not document Bipolar Disorder as a diagnosis for TR. Respondent also did not indicate his reason for prescribing Lamictal.
- 5. During the two years of treating TR, Respondent did not order laboratory tests, check TR's vital signs and coordinate with TR's primary care physician. There is no indication in the record that Respondent provided TR with informed consent discussing the risks, benefits and side effects of the medications he prescribed alone and in combination.
- 6. In response to the Board's Investigation, Respondent provided the Board with TR's medical records. TR's record included medical record notes from another patient's medical record, contradictory notes and random progress notes that were all.

difficult to read including pages of unsigned shorthand notes appearing to belong to a different medical record; notes with more detail that encompasses the full page with a different format than the other notes; notes with letters repeatedly written over to make them darker, several cribbed notes written in the margins and notes changing TR's diagnosis without indication. On one of the progress notes Respondent documented TR is legally blind. There is no other reference to this in any of the notes. Also, there is no indication in TR's record for this diagnosis. Respondent also documented in TR's record "stated hospitalization, Bipolar disorder, Lithium and Tegretol," which does not fit with TR's medical record, indicating it may be from another patient's medical record.

- 7. The standard of care requires a physician to prescribe a medication and treatment for a patient that is consistent with the diagnoses and target symptoms and provide indications for treatment.
- 8. Respondent deviated from the standard of care because he prescribed Lamictal for TR even though it was not consistent with his diagnoses and TR's target symptoms and he did not provide indications for this treatment.
 - 9. TR could have suffered side effects from the unnecessary medication.
- 10. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did not document his indications for his diagnoses for TR, he did not document his indications for prescribing Lamictal to TR and he did not document his indications for prescribing to KR.

- 11. During the investigational interview with Staff, Respondent admitted to providing samples of Wellbutrin and Stattera to TR for her daughter ("KR"). Respondent stated he did not examine or interview KR in person as she was in Texas, however, he asked KR questions over the telephone and from those conversations he prescribed the medications. Respondent also admitted to not listing his indications for prescribing to KR.
- 12. On August 22, 2006, Respondent was ordered to undergo an evaluation at the Sexual Recovery Institute ("SRI"). The evaluation showed Respondent was capable of faulty judgment, ill advised patient confidentiality, and that he may be psychologically incapacitated. On September 19, 2006, Respondent entered into an Interim Consent Agreement restricting him from practicing clinical medicine or any medicine involving direct patient care and prohibiting him from prescribing any form of treatment including prescription medications. Subsequently, Respondent left the practice of medicine and did not renew his Arizona license.

CONCLUSIONS OF LAW

- The Board possesses jurisdiction over the subject matter hereof and over Respondent.
- 2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.") and A.R.S. §32-1401(27)(ss) ("[p]rescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . . .").

IT IS HEREBY ORDERED THAT: Respondent is Issued a Decree of Censure. day of ARIZONA MEDICAL BOARD By: LISA S. WYNN **Executive Director** ORIGINAL of the foregoing filed this 2nd day of 2001, 2009 with:

ORDER

2009.

EXECUTED COPY of the foregoing mailed this 2" day of (love)

Debbie Hill Osborn Maledon The Phoenix Plaza, 21st Floor 2929 N Central Avenue Phoenix AZ 85012-2765

Arizona Medical Board

Scottsdale, AZ 85258

9545 E. Doubletree Ranch Road

EXECUTED COPY of the foregoing malled this 2009 to:

Robert D. Castillo, M.D. 22 Address of Record 23

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Investigational Review